2. REPORT DATE	3. REPORT TYPE AND DATES COVERED
December 1991	Final Report (07-00 to 07-91)

4. TITLE AND SUBTITLE
Controlling Costs for Inpatient CHAMPUS Psychiatric Care

5. FUNDING NUMBERS

6. AUTHOR(S)
CPT Bobbette A. Smith, MS

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)
Bayne-Jones Army Community Hospital
Fort Polk, LA
71459-6000

8. PERFORMING ORGANIZATION REPORT NUMBER
22a-91

9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)
U.S. Army-Baylor University Graduate Program in
Health Care Administration
Academy of Health Sciences, U.S. Army (HSHA-MH)
Fort Sam Houston, TX 78234-6100

10. SPONSORING/MONITORING AGENCY REPORT NUMBER

11. SUPPLEMENTARY NOTES

12a. DISTRIBUTION/AVAILABILITY STATEMENT

DISTRIBUTION STATEMENT A
Approved for public release
Distribution Unlimited

12b. DISTRIBUTION CODE

13. ABSTRACT *(Maximum 200 words)*

14. SUBJECT TERMS

15. NUMBER OF PAGES
90

16. PRICE CODE

17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT
N/A	N/A	N/A	UL

CONTROLLING COSTS FOR INPATIENT CHAMPUS PSYCHIATRIC CARE

A Graduate Management Project

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Administration

by

Captain Bobbette A. Smith, MS

December 1991

Acknowledgments

The idea for this project began during the didactic phase of the Baylor program in the Strategic Management course. My thanks to LTC F.W. Brown for initiating this new class which led to the develop of my thesis. Also, I would like to thank my fellow group associates from that class: MAJ Al Giambone, CPT Mary Carstenson, and CPT Jim Rosengren. Together we developed the initial ideas for this paper and they have been the foundation of my thesis.

My thanks to the staff of Bayne-Jones Army Community Hospital for supporting me in all my endeavors. The MEDDAC Commander, Colonel Fred Cecere, is a tremendous supporter of the Baylor program and provided me with his support and a wonderful learning environment throughout the year. This past year has been a truly unique academic experience and it has been my complete good fortune to work for a very talented, wise man who is a gifted teacher and mentor. My thanks to Colonel Doug Barton who provided me with his support, encouragement and sage advice. He is a role model for all preceptors - and the role model I will strive to emulate throughout my career.

ABSTRACT

In the past ten years, the costs for mental health treatment in the civilian health care sector have increased at more than twice the rate of general health care costs. Reimbursements for the cost of mental health treatment now represent approximately 20 percent of all health care insurance dollars. The Department of Defense reports roughly the same kind of excessive growth for psychiatric care costs paid by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Even in small military communities, like the Bayne-Jones Army Community Hospital's (Fort Polk, Louisiana) catchment area, dollars spent on inpatient psychiatric care have increased by over 180 percent in the last four years alone. This project discusses the history behind this unusual growth and analyzes various courses of action utilizing new programs available (Gateway, Partnerships, VA-DOD Resource Sharing, Alternative Outpatient Therapy) to reduce the growth of CHAMPUS inpatient mental health care costs.

TABLE OF CONTENTS

Introduction

In 1960, $50 billion was spent on national health care, which equated to 5 percent of the Gross National Product (GNP). By 1988, that percentage had increased to 11 percent, or $604 billion. The total health care costs for 1990 for the United States are estimated at approximately $676 billion (AHA 1991). However, during this same time period, expenditures for mental health care rose at twice the rate of general medical costs (Zimet 1989).

From 1987 to 1988, the cost to employers for providing mental health benefits (to include substance abuse) increased from $163 to $207 per employee. This represents a cost increase of 27% in one year (Stack 1989). Some experts estimate that the cost of adolescent mental health care rose by as much as 40% during this same time period (Hagin 1989). 30 per cent of the workers' health plan dollars are now spent to treat mental health problems (Hagin 1989).

The reasons for this tremendous growth in the mental health market are multi-dimensional, but are primarily attributed to: a rapid expansion in the number of for-profit psychiatric treatment facilities, an increase in the utilization rate for psychiatric care, and past reimbursement practices of insurance policies which traditionally

favored inpatient treatment. The continued growth in mental health care costs has put tremendous pressure on business to implement a managed care program for mental health care benefits (Larkin 1989).

The Department of Defense (DOD) has also seen tremendous growth in the cost of providing health care for its 9 million beneficiaries. From 1985 to 1987, total DOD health care costs increased by 21.6 percent, to a total of $ 9.53 billion. During this same period, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) grew at a rate of 43 percent, totaling approximately $ 2 billion (GAO 1989). CHAMPUS costs reached $ 2.5 billion in fiscal year 1989, and now represent nearly 20 per cent of total DOD health care expenses. This rapid growth in the overall cost of the CHAMPUS program has brought new emphasis from DOD, directed to all military medical treatment facilities, to seek out new methods to curtail the growth of CHAMPUS.

Bayne-Jones Army Community Hospital's catchment area also reflects this tremendous growth rate in the use of the CHAMPUS program by its beneficiaries. From calendar years 1986 through 1989, the cost of the CHAMPUS program for this catchment area grew from $ 4.75 million to $ 8.51 million, a 79 percent increase. The primary

category of health care that this growth can be attributed to is mental health. The cost of mental health care grew from $ 1.34 million in 1986 to $ 3.80 million in 1989 ($ 3.5 million or 91% spent on inpatient care), an increase of 184 percent (the increase from 1988 to 1989 alone was 77 percent). All other categories of care grew at a rate of 38 per cent from 1986 to 1989. Mental health CHAMPUS costs now account for approximately 48 percent of the total CHAMPUS budget for this catchment area.

During this time period, the beneficiary population that B-JACH supports has remained stable (approximately 70,000), with no policy changes in inpatient treatment capabilities regarding the CHAMPUS eligible population. B-JACH's inpatient psychiatric bed capacity is 16 beds, which have been used almost exclusively for the treatment of active duty military personnel. The majority of dependents of active duty personnel, retirees, and their dependents receive inpatient psychiatric treatment at local civilian psychiatric treatment facilities with reimbursement via CHAMPUS.

Problem Statement

CHAMPUS Inpatient Psychiatric Care costs have increased by 184 per cent over the last four years for the B-JACH catchment area and it appears this trend will continue (77 per cent growth in most recent year). This is an excessive rate which must be brought under control given the current environment of decreasing resources, cost containment and managed care.

Review of the Literature

"The 1990s have officially been designated 'The Decade of the Brain' under a congressional resolution passed in 1989 to encourage research that will greatly expand our capacity to understand mental disorders and treat them effectively." (Hoppszallern 1991, p. 66) There is tremendous demand for mental health care: the National Institute of Mental Health estimates that 1 American in 5 (29.4 million) suffers from a mental illness (Hagin 1989). Indeed, the cost of providing care for this increasing population continues to outpace cost increases in the general health care sector. Psychiatric care continues to be one of the fastest

growing sectors of the hospital industry with the direct cost of clinical care for psychiatric disorders now totaling more than $ 40 billion per year (Hoppszallern 1991). It will be the challenge for the decade to find the answer to providing mental health services at reasonable prices which will truly establish this as "The Decade of the Brain".

The market for mental health care has undergone rapid change in the past decade from both a consumer and seller perspective. Since 1980, the demand for mental health services has tripled (Fox & Gottheimer 1990). To meet this increased demand (or perhaps in reaction to stimulated demand), the for-profit civilian mental health sector has rapidly expanded the number of psychiatric hospitals. "According to The AHA Hospital Statistics, investor-owned, for-profit psychiatric specialty hospitals in the United States increased by 60 percent from 1984 to 1989, while the number of U.S. psychiatric hospital beds increased by 56 percent." (Hoppszallern 1991, p. 67) The federal psychiatric hospital sector during this same time period decreased the number of its facilities by 16 per cent, and beds by 47 per cent. Much of this decline in the federal sector can be attributed to the efforts of the government towards the "deinstitutionalizing" of the mentally ill (Hoppszallern 1991).

Obviously this trend from the public to the private sector has had a marked impact on the delivery of mental health care. "Low capital costs, long lengths of stay, and favorable reimbursement trends can make a psychiatric unit one of the most lucrative of all hospital product lines, helping to offset declining occupancy rates." (Hagin 1989, p. 20) A twenty bed or larger facility can generate profits in excess of $ 2.5 million per year (Hagin 1989). Estimated profit margins for the mental health care market range from 28 to 30 per cent (Zimet 1989). Contrast this with the recently released news on profit margins in acute care hospitals: the overall hospital net operating margin dropped from 5 per cent in 1989 to 4.8 per cent in 1990. The non-patient revenues contributed the needed black ink by supplying 5 per cent of all hospital revenues (Impact Weekly 1991).

One of the most lucrative segments of the mental health care market is the adolescent population. The American Psychological Association estimates "...that in any six-month period, 7.5 million children under the age of 18 will have some form of psychiatric illness." (Westbrook 1988, p. 36) From 1970 to 1980, adolescent admissions to private psychiatric hospitals or private residential treatment cents increased by 130%. On the average, treatment for adolescents may cost

50 percent of the total budget of a company's mental health care dollars. This is partially due to the fact that adolescent stays may be two to three times the adult norm. (Westbrook 1988)

"Insurance and business sources agree. They say that businesses around the country are desperate to contain the explosion in mental health benefit costs." (Larkin 1989, p. 64) A revolution has begun from employers, third party payers, and others who pay the bills for the high cost of inpatient mental health care treatment (Goldstein & Horgan 1988). They are demanding an alternative course of treatment to the traditionally expensive inpatient treatment model (Fox & Gottheimer 1990).

Unfortunately, one of the primary reasons for the advent of the expensive inpatient model as the preferred mode of treatment was the attitude of the businessman towards psychiatric care, "If treatment is a medical necessity, then surely the patient should be hospitalized." (Zimet 1989, p. 704) This overriding attitude assisted in the widespread use of medical insurance plans (including Medicare and Medicaid) which allowed reimbursement for inpatient care, but rarely reimbursed for less expensive outpatient therapy (Zimet 1989). Another failure in the inability to control mental health care costs is attributed to the

disagreement between health care practitioners in many cases on appropriate standards of care for psychiatric treatment, thereby limiting the use of precertification and concurrent review that has worked well in controlling cost in medicine and surgical practices (Stack 1989).

Even with these roadblocks, the future of mental health will be under the managed care model. "Managed care programs seek to control access to health care services, monitor the medical necessity of the proposed services, and ensure that services are delivered in a cost-effective manner." (Hoppszallern 1991, p. 72) Insurers, HMOs and employers will aggressively pursue curtailing the overuse of inpatient hospitalization. "Demand for inpatient care may actually decline in coming years because of the push by employers to have workers and their families use outpatient programs, and even then, only when necessary and appropriate." (Hagin 1989, p. 20) The rush by suppliers of psychiatric care to build/renovate facilities for inpatient treatment has slowed and alternatives to inpatient settings are being developed (the growth in total psychiatric hospital beds was only 5.6% from 1988 to 1989) (Hagin 1989).

This leads us to the interesting dilemma now confronting the mental health care industry: the battle over the managed care mental

health care model. Of course there are providers of mental health care services who believe attempts to change to a managed care model are "... a direct intrusion on professional autonomy and judgment." (Sharfstein 1990, p. 966) The American Psychological Association (APA) has gone so far as to argue before Congress that managed care and utilization review should be prohibited by federal law or regulation (Tischler 1990). Yet, when utilization rates are analyzed for appropriateness, problems have been identified. "Recent statements issued by the APA and the American Academy of Child and Adolescent Psychiatry express concern that mental hospitals and psychiatric wards are becoming the jail cells for problem middle- and upper-income kids. Some hospitals use "scare tactics" advertising to persuade parents to admit children into an inpatient program - even those children who might be better served by a private counselor or group counseling program." (Hagin 1989, p. 22)

Although utilization rates for psychiatric care have changed in the past decade, studies indicate that only some 20% of those suffering from a psychiatric disorder receive treatment for them (Hoppszallern 1991). Consumer attitudes have also begun to change regarding mental health treatment: the stigma surrounding mental health care has begun

to fade. This could have a tremendous impact on future mental health care utilization rates. "Since 80% of all people with diagnosable mental illness do not seek treatment, small changes in attitudes toward treatment can have a major effect on patient volumes." (Fox & Gottheimer 1990, p. 16) "Because the incidence of mental illness is on the rise and because the cost for treatment is going up (for some organizations as high as 25% per year), providers and consumers must work together to find solutions." (Westbrook 1988, p. 38)

Managed care, with its utilization review orientation, appears an appropriate answer for containing mental health care costs. It also shifts the locus of care from an inpatient to an outpatient setting. "Day and evening partial hospitalization programs, intensive outpatient treatment, short-term inpatient crisis intervention, residential treatment programs, and employee assistance programs are examples of programs designed as alternatives and complements to inpatient hospitalization." (Hoppszallern 1991, p. 72) Alternative outpatient mental health care treatments have proven to be just as effective as the traditional inpatient setting at 25% to 50% of the cost (Fox & Gottheimer 1990, Hagin 1990, Goldstein & Horgan 1988). The judicious use of alternative outpatient therapy as a new model for mental health care could prove to be an

effective solution for bringing escalating mental health care costs under control.

Background

The Department of Defense operates the largest health care organization in the United States with 132 hospitals and 394 clinics serving 9 million beneficiaries. Of the approximately nine million beneficiaries, 2.3 million are active duty military personnel who receive their care through the direct care-Military Treatment Facility (MTF) system. 2.8 million are dependents of active duty personnel and the remaining 3.7 million are retirees and their dependents.

The Civilian Health And Medical Program of the Uniformed Services (CHAMPUS) is a health plan for non-active duty beneficiaries. It was designed to provide care to this beneficiary group when care could not be provided at the Medical Treatment Facility (MTF) due to location, lack of capacity, or when professional or equipment capabilities were not available within the MTF for the procedure or treatment. This program was not meant to become the primary means of providing care to this beneficiary group, but as a supplement to the direct care system.

However, this program has grown in costs so quickly that it now represents nearly 20% of the total DOD health care expenditures (GAO 1990). From fiscal year 1985 to 1989, CHAMPUS program costs grew from $ 1.4 billion to $ 2.5 billion, demonstrating a 78% increase.

During that same time period, the workload in MTFs decreased. Between 1985 and 1987 there was a decrease of 64,800 admissions to MTFs. This was accompanied by a 50,800 increase in CHAMPUS admissions during the same time period. Of these 50,800 admissions, 49,900 (or 98%) of the beneficiaries being admitted lived within a MTF's catchment area (a catchment area represents an area approximately 40 miles in radius from a MTF). Although some of the reduction in workload at the MTFs was attributed to quality assurance functions, a reduction in specialists, and an increased emphasis on readiness and training, there was also an increase in the utilization rates of beneficiaries as well as marked increases in the overall cost of providing health care. (GAO 1989)

This rapid escalation in the cost of the CHAMPUS program left DOD scrambling for solutions to quickly curtail its rate of growth and attempting to find new models for providing health care to the beneficiary population. Although CHAMPUS utilization does involve a

co-payment by the beneficiary, it seemed to be inconsequential in curtailing the rate of growth. Part of this is due to the fact that dependents' of active duty personnel co-payment is very small for inpatient stays (approximately $ 8/day), and many retirees have additional insurance that covers their co-payment (25% or $210/day). (GAO 1987).

VA-DOD Sharing Agreements

The Department of Defense has not been idle in developing and implementing innovative projects to better utilize its resources in providing health care to its 9 million beneficiaries. In May of 1982, new legislation was enacted, termed the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act (Public Law 97-174). This piece of legislation was not without its problems. One of its primary purposes was to allow for a sharing of health care resources to maximize utilization and prevent redundant services from being developed when VA and DOD hospitals were located short distances from each other. This legislation had the potential for big cost savings given that the VA and the DOD operate more than 300 hospitals and 600 outpatient clinics in the fifty states.

Three years after the legislation had been enacted, approximately 240 sharing agreements had been implemented, though the cost savings to the government had not been determined. (GAO 1988)

Certain obstacles to increased cost savings had also been identified by the end of the first three years. Those obstacles include the following: reimbursement rates set at a noncompetitive level which reflected total costs instead of variable costs; a lack of incentive due to cost savings being put back into the DOD budget instead of the budget of the individual Medical Treatment Facility (MTF) who initiated the sharing agreement; and restrictions by law of treating CHAMPUS eligible beneficiaries and receiving reimbursement from CHAMPUS for services provided. The restrictions on CHAMPUS reimbursement and treatment of beneficiaries in this program proved a real stumbling block between GAO and the Office of Management and Budget (OMB). OMB strongly disagreed with GAO's recommendations to allow for the treatment/ reimbursement of CHAMPUS beneficiaries. Finally, in late November 1989, legislation passed which amended the original law, thus allowing for CHAMPUS beneficiaries/reimbursement to be included in the sharing agreements (though this category of beneficiary would have the lowest priority at VA facilities). There is still much

confusion and a lack of communication regarding this program within the VA/DOD systems. (GAO 1988)

Military-Civilian Health Services Partnership Program

USC Code Section 1096 enacted the legislation which allowed for use of partnership agreements between military treatment facilities and civilian health care providers. Resources covered under these sharing agreements could involve: personnel, equipment, supplies, and any other items or facilities necessary for the provision of health care services. These agreements would provide more medical opportunities for care for CHAMPUS beneficiaries by bringing civilian providers into the MTF to provide care (an internal agreement) or by sending our military staff to civilian health care organizations to provide care for CHAMPUS beneficiaries (an external agreement). The ability to expand care via the use of partnership agreements has been extremely successful in certain health care areas.

Alternative Delivery of Health Care/Alternate Use of CHAMPUS Funds Program

USC Section 1097 allowed for the Secretary of Defense to enter into a contract with any of the following health care providers: Health maintenance organizations, preferred provider organizations, individual providers, individual medical facilities, or insurers, and consortiums of such providers, facilities, or insurers. These contracts can cover selected health care services or total health care services for selected beneficiaries. Funding for these programs are recovered from the monies in the CHAMPUS budget, and transferred to the budget of the payer of the contract.

The CHAMPUS Reform Initiative (CRI)

The CHAMPUS Reform Initiative is a new program initiated by DOD to attempt to lower the rate of CHAMPUS growth. This program's orientation, however, is to contract with private industry for the management of the program and the delivery of medical care to CHAMPUS beneficiaries. Originally, the initial CRI contract allowed for a five state test area (Hawaii, California, New Mexico, Arizona, and Nevada), but during the initial test of the program only Hawaii and California were included in the program. The goals of CRI are: 1. contain CHAMPUS costs for both beneficiaries and the government; 2.

improve access to care; 3. assure quality of care; 4. simplify CHAMPUS administrative procedures; and 5. improve coordination between the MTF and CHAMPUS. (GAO 1987)

CRI was implemented in 1988 and had its share of difficulties. During 1990 Congressional testimony, the determination of whether or not the CRI program was succeeding in achieving its stated goals was still unclear. DOD claimed that the growth in CHAMPUS costs in the test site area was lower than the growth that would have taken place without CRI, but this could not be statistically substantiated due to a lack of data. This contract will expire in January of 1993 unless it is renewed by DOD. (GAO 1990)

Catchment Area Management (CAM)

Catchment Area Management takes a different orientation in attempting to control CHAMPUS costs compared to the CHAMPUS Reform Initiative. CAM is based on the viewpoint that the local MTF Commander is the medical expert for that catchment area and has the best knowledge of how to most effectively use his resources in providing care to all his eligible beneficiaries. CAM is also based on the

belief that DOD does not need to contract to outside corporations to provide the expertise needed to move to a managed care environment, but possesses their own military experts on staff who can make this happen. Under CAM, the hospital commander is given his usual operating budget. Additionally, the monies associated with CHAMPUS costs for the catchment area are added to the budget.

This movement to allowing the local area commander control over his CHAMPUS dollars is absolutely key in achieving control over the CHAMPUS budget. Without this mechanism, there is no incentive to the local area commander to save CHAMPUS dollars. Data have shown that caring for patients within the military hospital system costs, on average, from 43 to 52 percent less than CHAMPUS funded care (GAO 1990). CAM opened the gate needed for the local commander to control CHAMPUS funds at last.

GATEWAY TO CARE

"At CAM sites the hospital commander coordinates care and resources. In CRI, a civilian contractor does. In this respect, Gateway resembles CAM. But unlike either CAM or CRI, Gateway will be an integral and permanent part of an Army Hospital's operations." (Noyes

1991, p. 12) From both tests projects (CRI and CAM), the Army has taken the best ideas of each and implemented their new program, "Gateway to Care." Gateway will now allow all hospital commanders to develop their own coordinated care (managed care) system personally tailored to meet the needs of their local resources and requirements. Currently, Gateway is being phased in over a three year period for all Army MTFs. However, Health Services Command (HSC) has encouraged all MTFs to begin identifying areas of health care services that would benefit using Gateway to expand services and to initiate actions to begin these projects as quickly as possible. (Personal communication with Chief of Coordinated Care).

PURPOSE AND OBJECTIVES

The purpose of this study is to identify the most efficacious procedures and policies for B-JACH to implement to bring their CHAMPUS inpatient mental health care expenses under control. Given the many new programs currently available (Gateway, Alternative Use

of CHAMPUS funds, etc.), implementing changes in current procedures will probably be necessary to optimize this goal.

Objectives:

1. Analyze past utilization patterns for CHAMPUS sponsored mental health care for the B-JACH catchment area. Identify trends, primary inpatient mental health diagnoses for the population, and conduct an analysis of the users by age, sex, and beneficiary category and average costs associated with CHAMPUS inpatient mental health admissions.

2. Compare CHAMPUS reimbursement costs for the B-JACH catchment area to other similar size Army MTFs, to include: average length of stay, cost per day, and average cost of admission.

3. Analyze current utilization patterns for inpatient mental health care provided at B-JACH, to include: average length of stay, primary diagnoses, cost of admission, reimbursement rates, beneficiary category, and occupancy rates. Compare utilization rates by beneficiary group to other similar size MEDDACs.

4. Determine current policies regarding the issuance of Non-Availability Statements (NAS) for inpatient psychiatric care and compare the rate of retroactively issued NASs to other MTFs.

5. Research developing a partnership agreement with a local civilian health care agency for providing mental health care for the B-JACH beneficiary population, or a portion thereof. Identify past trends in civilian facilities market shares, current rates of reimbursement, and the potential for developing an agreement.

6. Investigate the feasibility of entering into a VA-DOD Resource Sharing Agreement with the local VA hospital and determine if this could be a viable answer to providing increased mental health capacity in the direct care system.

7. Analyze the opportunities for implementing alternative outpatient mental health care treatment in lieu of (or in conjunction with) traditional inpatient care. Determine the most appropriate diagnoses to treat on an outpatient basis, and approximate savings from implementing this change.

METHODOLOGY

Analysis of Past Utilization of CHAMPUS Funds

One of the most key factors in marketing a program is to understand the utilization pattern of your customers. Using fiscal year 1989 DEMIS data, the population of the B-JACH catchment area was segmented into various groups: male, female, active duty, dependents of active duty, and retirees and their dependents.

Using CHAMPUS data, (provided by OCHAMPUS health care summary by primary diagnosis reports for calendar years 1986-1989), total government costs for all medical care paid by CHAMPUS for the B-JACH catchment area were calculated. Those costs were further broken down to reflect the cost of inpatient psychiatric admissions. Data from this four year time period was then analyzed to identify trends in CHAMPUS growth.

Using FY1989 OCHAMPUS data, (CHAMPUS Health Care Summary by Diagnosis Report), the average cost per psychiatric admission was calculated. Using data from the FY1989 Total CHAMPUS Inpatient Care by Diagnosis Code Report for the B-JACH

catchment area, high volume diagnoses were identified. Costs per admission were then calculated for those high volume diagnoses.

The average cost per psychiatric admission and the average number of total admissions was calculated for 1986-1989 using the OCHAMPUS data. Utilization rates were then calculated from those figures by beneficiary group.

Copies of all Non-Availability Statements (NAS) issued by B-JACH for fiscal years 1989 and 1990 were obtained from the B-JACH CHAMPUS advisor. The data from these NASs were then entered into a data base management software program to conduct a more detailed analysis of utilization patterns. Using the data base reports, utilization by age, sex, and beneficiary category was then calculated. Another database report sorted the data into groupings based on diagnosis, age and sex.

Compare B-JACH CHAMPUS Costs to other MEDDACs

A Comparative Indicator Report by OCHAMPUS based on data for the Army Catchment area during FY 1989 provided information on inpatient mental health care costs for 15 similar sized MEDDACs, (termed Group 2 MEDDACs as defined by HSC). From the data

provided, total mental health care costs, average length of stay, average cost per admission, and average cost per day were calculated. A statistical analysis was performed comparing utilization rates for B-JACH to the other MEDDACs using Microstat® software provided by the Baylor Program.

B-JACH Inpatient Utilization Rates

Reports on occupied bed days for B-JACH from 1984 through 1990 were obtained from the Resource Management Division of B-JACH. Information from Monitrend® reports was also used to identify the average inpatient revenues, costs per patient day, and direct expenses per patient day. This data was then compared to UCAPERS workload data. UCAPERS reports were also used to compare the average expense per occupied bed day for B-JACH to the other Group 2 MEDDACs.

To determine utilization rates among other facilities, a special study on B-JACH and the other Group 2 MEDDACs was conducted by Patient Administration Systems and Biostatistics Agency (PASBA) which provided a detailed analysis of inpatient psychiatric utilization rates for the Group 2 MEDDACs which included an analysis of : beneficiary

category, admissions, length of stay, and a one-way anova of B-JACH inpatient utilization compared to the group rates.

Issuance of Non-Availability Statements at B-JACH

The CHAMPUS Advisor for B-JACH briefed me on the CHAMPUS program and provided me all of the pertinent regulations and policy information pertaining to CHAMPUS that she had available. This included policies regarding catchment areas, NASs, emergency care, and various other topics.

Using data provided from a report on "CHAMPUS and Health Care Operations for August 1989" which was based on PASBA data, the average number of retroactively issued NASs was calculated for the Group 2 MEDDACs. This provided a basis of comparison for B-JACH.

The number of NASs that B-JACH issued retroactively during FY 89 for inpatient mental health care was then calculated using information from the database file. This data was then compared to the number of NASs issued for the entire CHAMPUS catchment area as reported from 1987 to 1989 OCHAMPUS Summary reports.

It is important to note that even if a beneficiary resides within the B-JACH catchment area, that does not necessarily mean that the

beneficiary will obtain his NAS from B-JACH. The beneficiary may obtain a NAS from other MTFs as well. It is important to calculate the utilization data from our own B-JACH issued NASs, and then compare it to the total admissions requiring a NAS category billed to the entire catchment area in the OCHAMPUS summary reports.

The B-JACH CHAMPUS advisor also provided me with information on a new external utilization review agency, Health Management Strategies (HMS), which DOD has contracted with to manage its utilization management program for CHAMPUS Inpatient Psychiatric care. An analysis was conducted to identify any initial cost savings generated by that new program using OCHAMPUS reports for 1988, 1989, and 1990.

Partnership With A Civilian Psychiatric Facility

Three civilian for-profit freestanding psychiatric care facilities currently receive the vast majority of B-JACH CHAMPUS patients. A detailed analysis of these usage patterns was conducted using data from 1988 and 1989 B-JACH NASs. (OCHAMPUS would not provide any data on institution specific utilization or costs.) A breakdown by facility was conducted, as well as by physician referral, for all psychiatric

facilities. LTC Lee Driggers, the Chief of the Resource Management Division, provided me with information pertaining to the background of events in establishing partnership programs with these facilities in the past. Three facilities were surveyed for interest in participating in a proposal for partnership agreements. Three facilities were analyzed for scope of care that could be provided at each institution. Interviews with the administrators of two of the facilities were conducted to determine interest levels for becoming involved in the Partnership Program with B-JACH.

VETERANS' ADMINISTRATION/DOD RESOURCE SHARING AGREEMENT

Interviews were conducted with key staff members from both B-JACH and the VA hospital in Alexandria, Louisiana, to determine attitudes and interest in VA-DOD Resource Sharing between the facilities. Plans to implement a Resource Sharing Agreement were discussed, to include: reimbursements, capacity, capability to treat various diagnoses, staffing, etc.

USE OF ALTERNATIVE MENTAL HEALTH PSYCHIATRIC THERAPY

Possible utilization of alternative outpatient treatment for certain diagnoses were identified and discussed with the Chief of the Inpatient Psychiatric Ward at B-JACH. A target group to implement this strategy was identified. Increased resources needed to support the program were discussed with the Chief, Inpatient Psychiatry and the Chief, Resource Management Division. Projected cost savings were based on CHAMPUS costs from FY 1989.

FINDINGS

Analyze Utilization Patterns for CHAMPUS:

Using DEMIS data, the population groups for the B-JACH catchment area are listed in table 1. The dependents of active duty group comprise the largest segment of the population representing fully half of the total population. This group is also dominated by females - which is logical given the preponderance of males in the active duty population. Because only dependents, retirees, and dependents of retirees are entitled to use the CHAMPUS program, this shift to a majority of females in this beneficiary group will become key in analyzing utilization patterns under CHAMPUS.

Table 1. Population by Group and Sex

	Active Duty	Dependents Active Duty	Dependents Of Retired	Total
Male	13,285	6,504	3,217	22,966
Female	1,294	14,793	3,459	19,556
Total	14,579	21,297	6,676	42,552

From calendar year 1986 through 1989, total government costs for CHAMPUS for the B-JACH catchment area increased by 79 percent. However, during this same period, government costs for CHAMPUS inpatient psychiatric care rose by 207 percent. Table 2 reflects the growth in the CHAMPUS program during this time period. By the end of 1989, inpatient mental health costs represented 56 percent of all inpatient CHAMPUS costs and fully 41 percent of the entire CHAMPUS budget for the B-JACH catchment area.

Table 2. CHAMPUS Growth from 1986 through 1989 for B-JACH

Year	Total Government Costs	Government Inpatient Psychiatric Costs
1986	$4,750,268	$1,130,260
1987	$5,620,957	$1,473,722
1988	$6,260,592	$1,927,596
1989	$8,509,434	$3,470,731

Table 3 depicts the growth in the number of inpatient admissions for the B-JACH catchment area for mental health treatment and the average government cost for each admission. Average government cost per admission held relatively constant throughout this period, increasing

by a total of 16 percent from 1986 to 1989. The utilization rate, however, increased by 165 percent during this four year period with a one year high increase of 76 percent from 1988 to 1989.

Table 3. CHAMPUS Inpatient Psychiatric Admissions

Year	Admissions	Average Government Cost Per Admission
1986	91	$12,421
1987	117	$12,596
1988	137	$14,070
1989	241	$14,401

Within the beneficiary groups, utilization rates among the groups as a percent of the whole did change, with a marked increase of 8 percent for dependents of active duty personnel. Table 4 depicts this trend. During this four year period, all user groups increased their utilization rates overall, from a rate of 71 percent (retirees) to over 200 percent (dependents of active duty). The highest single growth period was for dependents of active duty from 1988 to 1989 which reflects a 82% increase in total utilization from the previous year's rate.

Table 4. Utilization Rates for Beneficiary Groups

Year	Dependents Active Duty	Retirees	Dependents/Survivors Retirees
1986	64 (.70)	7 (.08)	20 (.22)
1987	77 (.72)	6 (.06)	24 (.22)
1988	107 (.78)	4 (.03)	16 (.19)
1989	195 (.78)	12 (.05)	44 (.18)

Using the data from Non-Availability Statements (NAS) issued by B-JACH for fiscal years 1989 and 1990, the number of psychiatric admissions by age and sex are listed in Table 5. If you exclude the active duty military population from the DEMIS data, the total percentage of females and males in the remaining population is 68% and 32% respectively. One can determine from the data in Table 5 that the utilization pattern for inpatient mental care for females and males match these percentages exactly. There are several interesting points to be made from these utilization patterns. First, fully 78% of all inpatient psychiatric care is being utilized by patients under the age of 35. Secondly, the 25-34 age range for women accounts for 36% of all

inpatient psychiatric utilization, with the most common diagnosis that of depression.

Table 5. NAS Utilization by Age and Sex

Age Group	Female	Male	Total
5 - 14	18 (6%)	36 (12%)	54 (18%)
15 - 17	23 (8%)	27 (9%)	50 (17%)
18 - 24	46 (15%)	15 (5%)	61 (20%)
25 - 34	63 (21%)	8 (3%)	71 (24%)
35 - 44	27 (9%)	2 (1%)	29 (10%)
45 - 64	27 (9%)	9 (3%)	36 (12%)
>65	0 (0%)	0 (0%)	0 (0%)
Total	204 (68%)	97 (32%)	301 (100%)

The primary diagnoses (as listed by the physician on the justification for the NAS) are listed in Table 6. These six diagnoses account for 81% of all admissions. This data is based on 281 NAS records from FY 1989 and FY 1990. Admissions for depressions or substance abuse account for fully 60% of all admissions.

Table 6. Primary Diagnoses for Inpatient Admissions

Diagnosis	Number of Admissions	Percent of Total Admissions
Depressions	123	44
Substance Abuse	45	16
Schizophrenia	16	6
Adjustment Disorders	15	5
Conduct Disorders	15	5
Oppositional Disorders	15	5
Total	229	81

Some diagnoses are more prevalent among specific age groups. Table 7 depicts the first and second most common diagnoses displayed by age and sex.

Comparing these preadmission diagnoses to the actual diagnoses as billed to CHAMPUS results in very similarly represented groups for the catchment area. This data is depicted in Table 8. The percentages for the preadmission diagnoses and the billed diagnoses are almost identical.

Table 7. Diagnoses by Age and Sex

Age Group	Females Primary/Secondary	Males Primary/Secondary
5 - 14	44% Depression 22% Conduct Disorders	49% Conduct Disorders 27% Attention Deficit Syndrome
15 - 17	26% Depression 22% Conduct Disorders	40% Depression 32% Conduct Disorder
18 - 24	43% Depression 22% Substance Abuse	33% Depression 33% Substance Abuse
25 - 34	62% Depression 19% Substance Abuse	63% Psychoses 13% Substance Abuse
35 - 44	52% Depression 19% Schizophrenia	50% Schizophrenia 50% Substance Abuse
45 - 64	33% Depression 19% Schizophrenia	55% Depression 45% Substance Abuse

Table 8. Diagnoses as Billed to OCHAMPUS

Diagnosis	Number of Admissions	Percent of Total Admissions
Depressions	99	46%
Substance Abuse	37	17%
Schizophrenia	15	7%
Adjustment Disorder	8	4%
Conduct Disorder	15	7%
Occupational Disorder	12*	6%
Attention Disorder	10	5%

* Listed as "Other emotional disturbances"

The average cost as billed to OCHAMPUS (using FY 1989 data) for an inpatient admission for the B-JACH catchment area was $ 14,443. The average cost for the top seven diagnoses as billed to OCHAMPUS are listed in Table 9. These seven diagnoses account for 75% of the total inpatient mental health care costs for the B-JACH catchment area. Admissions for depressions account for fully 46% of the total government inpatient bill. The average length of stay (LOS) for inpatient mental health for the B-JACH catchment area for all diagnoses is 28.8 days. The average cost per day is $501.

Table 9. Average Government Cost per High Volume Admits

Diagnosis	Average Cost Per Admission	Percent of Total Inpatient Cost
Depressions	$16,099	46%
Substance Abuse	$ 8,553	9%
Schizophrenia	$ 6,792	3%
Adjustment Disorder	$ 7,238	2%
Conduct Disorders	$20,323	9%
Attention Deficit	$20,202	6%

Compare CHAMPUS Costs of B-JACH Catchment Area to other similar sized MTFs

"Group 2" CONUS-based MEDDACs (as defined by Health Services Command) were used in determining a comparison for B-JACH's CHAMPUS rates compared to other catchment areas. OCHAMPUS provided information on requested Army catchment areas for fiscal year 1989 on which various data for comparison were calculated. Table 10 depicts the fifteen similar sized MEDDACs analyzed and the total government cost for their catchment areas' mental health care costs for FY 1989. Using the total days, admissions, and costs, average LOS, average cost per admission, and average cost per day were calculated. This information is depicted in Table 11.

Fort Polk compares favorably in almost all categories, average length of stay and average cost per admission are both below the mean average. The average cost per day ($501) is above the mean ($428), but is not statistically significant. Indeed, it is still within one standard deviation of the mean (+/- $84).

Table 10. CHAMPUS Costs for 15 MEDDACs

MEDDAC Location	Total Mental Health Costs for FY 1989
Fort Belvoir	$ 7,213,000
Fort Benning	$ 3,322,000
Fort Bragg	$ 7,353,000
Fort Campbell	$ 5,292,000
Fort Carson	$ 5,871,000
Fort Dix	$ 2,050,000
Fort Hood	$16,487,000
Fort Jackson	$ 1,613,000
Fort Knox	$ 5,095,000
Fort Leonard Wood	$ 3,107,000
Fort Ord	$ 1,346,000
Fort Polk	$ 3,423,000
Fort Riley	$ 4,194,000
Fort Sill	$ 6,078,000
Fort Stewart	$ 5,132,00
Mean Average	$ 5,172,000

Table 11. Mental Health Cost Data for 15 MEDDACs

Location	Number of Admissions	Average Length of Stay	Average Cost Per Admission	Average Cost Per Day
Belvoir	360	48.8	$ 20,036	$ 411
Benning	279	34.8	$ 11,907	$ 342
Campbell	215	66.5	$ 24,619	$ 370
Carson	468	35.8	$ 12,545	$ 350
Dix	129	28.1	$ 15,891	$ 566
Hood	621	68.3	$ 26,549	$ 389
Jackson	157	29.9	$ 10,274	$ 344
Knox	459	23.9	$ 11,100	$ 465
L. Wood	268	35.0	$ 11,593	$ 331
Ord	129	17.2	$ 10,434	$ 607
Polk	237	28.8	$ 14,443	$ 501
Riley	155	71.6	$ 27,058	$ 378
Sill	332	40.6	$ 18,307	$ 451
Stewart	333	31.6	$ 15,411	$ 488
Mean Average	320	39.1	$ 16,091	$ 428

B-JACH Inpatient Utilization Rates

B-JACH operates an inpatient psychiatric ward on the west wing of the 7th floor of the hospital. This ward has an operating level of 16 beds (maximum capacity of 18 beds) and is used primarily, though not exclusively, for active duty personnel. Table 12 depicts the past seven fiscal years of utilization of 7W expressed in occupied bed days. The percentage figure signifies the occupancy rate for the Psychiatric ward for that fiscal year. A 34 percent increase in occupancy is seen for this time period. Again, there is a surge in utilization from 1988 to 1989 (32% increase from previous year's projected total) as there was for CHAMPUS psychiatric utilization during that same year.

Table 12. Workload and Occupancy Rate from FY 84-90

Year	Occupied Bed Days	Percent Occupancy
1984	1852	32
1985	1837	31
1986	1685	29
1987	1482	25
1988	2388*	41
1989	3148	54
1990	2524	43

* Figures projected on two months of workload for year.

Using Monitrend® information for FY1990, average inpatient revenue per patient day equalled $ 396/day. Direct expenses associated with each bed day are approximately $ 155/day, with the majority of that attributed to salary expenses. Direct expense percent was identify as 86.

Comparative costs per bed day for psychiatric care among the Group 2 MEDDACs is illustrated in Table 13. This data is based on information provided by a detailed unit cost comparison report for the 4th quarter of FY 90 from information input into the UCAPERS data base. Unfortunately, there is a significant footnote to the report, which states: "Group cost/per averages are calculated by dividing the total expense amount by the total workload amount of each MTF in the group...it is not an average of the individual cost/per amount." Fort Polk is above the average cost per bed day, but it is not indicative of whether these costs are truly associated with the provision of inpatient mental health care versus an unrelated hospital expense.

Table 13. Cost Comparison/Per Bed Day Group 2 MTFs

Group 2 - Large MEDDAC	Expense/Occupied Bed Day
Fort Belvoir	*
Fort Benning	285.53
Fort Bragg	353.37
Fort Campbell	220.39
Fort Carson	357.26
Fort Dix	480.72
Fort Hood	323.15
Fort Jackson	294.03
Fort Knox	399.73
Fort Leonard Wood	483.36
Fort Ord	341.20
Fort Polk	436.51
Fort Riley	294.49
Fort Sill	311.90
Fort Stewart	523.31
Group Mean Average	344.48

* No inpatient psychiatric ward

The primary diagnoses for B-JACH psychiatric inpatients are listed in Table 14 (this data was obtained via PASBA using FY 90 dispositions). The top six diagnoses account for 81 percent of all dispositions. The average LOS is 7.19 days.

Table 14. B-JACH Diagnoses - Highest Frequency

Diagnosis	Dispositions	Average Length of Stay
Adjustment Reaction	142 (39%)	8.0
Alcohol Dependence	78 (21%)	5.8
Affective Psychoses	33 (9%)	7.8
Nondependent Abuse	19 (5%)	5.0
Poisonings	13 (4%)	6.5
Schizophrenic Psychoses	12 (3%)	10.5

B-JACH's average inpatient psychiatric population is predominately active duty military (80%). The majority of MTFs treat an even larger percentage of active duty personnel. Table 15 lists the Group 2 MTFs comparing numbers of active duty to non-active duty beneficiaries receiving inpatient mental health care at each facility. The total CHAMPUS inpatient mental health admissions are listed as well to

give a better depiction of the total inpatient mental health demand for each area.

Table 15. Comparison of Inpatient Populations at MTFs

MTF	MTF Active Duty Military	MTF Non-Active Duty Military	CHAMPUS Admissions
Belvoir	16	4	360
Benning	160	2	279
Bragg	620	4	657
Campbell	321	79	215
Carson	131	28	468
Dix	336	7	129
Hood	383	8	621
Jackson	455	15	157
Knox	156	47	459
L. Wood	200	15	268
Ord	264	58	129
Polk	293	72	237
Riley	436	8	155
Sill	114	14	332
Stewart	199	66	333
Totals	4,084	427	4,799

Of the total 9,310 admissions for psychiatric treatment, 48.5% were handled in the direct care system and 51.5% received care under the CHAMPUS program. Of the total admissions, 44% were active duty personnel.

Issuance of Non-Availability Statements at B-JACH

Non-Availability Statements (NAS) must be obtained at the MTF's CHAMPUS Office before seeking inpatient treatment using CHAMPUS if the beneficiary lives within an MTF's catchment area. An NAS for inpatient care is not required if the beneficiary lives outside of the catchment area. An NAS is not required for a medical emergency even if inpatient treatment will be required. See Appendix A for a complete definition of "medical emergency."

When a patient lives within a catchment area and receives non-emergency inpatient care, yet fails to obtain a NAS before being admitted to the facility, he or she may seek to obtain a NAS after the fact, or a NAS that is issued "retroactively." These retroactively issued NAS's were to be the rare exception to the standard rule, yet have become more and more common. Surveying a typical one month

period (PASBA Data) for the 15 Group 2 MEDDACs, Table 16 reflects the number of NAS's that were issued retroactively.

Table 16. Retroactively Issued Nonavailability Statements (NAS's)

MEDDAC	Total Issued	Number Retroactive	Percent Retroactive
Belvoir	64	29	45
Benning	85	61	72
Bragg	319	81	25
Campbell	133	52	39
Carson	147	35	24
Dix	108	41	38
Hood	341	162	48
Jackson	58	20	34
Knox	72	18	25
L. Wood	41	30	73
Ord	58	15	26
Polk	42	31	74
Riley	61	45	74
Sill	117	72	62
Stewart	77	50	65
Totals	1,723	742	43

The average number of NAS's issued for all of the MEDDACs is 43 percent, with B-JACH issuing 74% retroactively. What was to have been the exception is almost as common place as the rule. Emergencies, remember, do not require the issuance of a NAS and would not have inflated these numbers upwards.

This dramatic increase in retroactive NAS's is also noted for inpatient psychiatric care at B-JACH. Since 1988, the percentage of retroactively issued NAS's for inpatient psychiatric care has moved from 68% to 85% in 1989 and to 90% in 1990. The vast majority of these admissions were not a psychiatric emergency. In fiscal year 1989, OCHAMPUS declared only 3 percent (6) of the total inpatient psychiatric admissions for the entire catchment area an "emergency."

Let us now look at a 24 month period from July 1987 through June 1989 which covers all categories of inpatient CHAMPUS admissions for the B-JACH catchment area. Table 17 displays this time into 2, twelve month periods reflecting utilization among 3 categories of patients for inpatient care: 1. emergency treatment, no NAS required; 2. no NAS required, outside of catchment area; and 3. NAS required.

Table 17. NAS Utilization For Inpatient Care

Year	Emergency	No NAS Required	NAS Required
July 1987 - June 1988	88 (19%)	59 (13%)	310 (68%)
July 1988 - June 1989	98 (16%)	48 (8%)	454 (76%)

It is interesting to note that while "emergency" inpatient treatment increased by 10 (11%), "no NAS required" decreased by 11 (19%) and "NAS required" utilization increased by 144 (46%). It is the "NAS required" population that is most susceptible to management under a coordinated care program and it is from this population which the highest growth of mental health utilization stems.

CHAMPUS inpatient psychiatric care does not follow the overall utilization patterns as displayed in Table 17. Table 18 depicts the 3 categories' usage for FY 1989.

Table 18. NAS Utilization For Inpatient Psychiatry

Year	Emergency	No NAS Required	NAS Required
FY 89	6 (3%)	7 (3%)	203 (94%)

Fully 94 percent of inpatient psychiatric care does require a NAS, as compared to the 76 percent rate for all NASs. During FY 89, B-JACH

issued 149 NASs for inpatient psychiatric care. Therefore, of the total CHAMPUS admits for FY 89 (216), B-JACH controlled 73% of the issuance of NASs for psychiatric care. This represents $ 2,809,852 (90%) of CHAMPUS inpatient psychiatric care dollars and is the portion that B-JACH can influence through its NAS issuance policies. It is to this portion of the population that our efforts to manage care more effectively will be applied.

Quoting from the CHAMPUS policy manual, "A psychiatric admission would not normally be considered an emergency." (See Appendix A for the rules for inpatient psychiatric care admissions.) Yet, by virtue of issuing 85% NASs retroactively in FY 89, and 90% in FY 90, we have allowed these admissions to be handled as emergencies and have not made them follow the standard policies for receiving a NAS for inpatient CHAMPUS care.

As set forth by CHAMPUS guidelines (see Appendix B), the following steps are supposed to occur to obtain a NAS for inpatient psychiatric care: 1. patient is evaluated by a member of the psychiatric staff to ensure outpatient treatment would not be more appropriate; 2. physician fills out protocol paperwork (See Appendix D for an example) for admission; 3. physician checks to see if there is an available bed in

MTF; 4. if no bed is available, patient and their sponsor are sent to speak with the CHAMPUS benefits counselor to discuss options and benefits; 5. the NAS is issued; and 6. the patient and sponsor go to the facility of their choice.

The way the current system works (90% of the time in FY1990) to obtain an NAS for inpatient psychiatric care, simply proceed to step 6. Step 6 involves the patient and sponsor going directly to the civilian treatment facility. Step 7 is then added, which is when the sponsor comes back to B-JACH to obtain the NAS.

It was partially due to the fact of this type of abuse of the system for obtaining inpatient psychiatric care that DOD initiated a contract with an organization called "Health Management Strategies" (HMS) to begin utilization review on all CHAMPUS psychiatric admissions. This was initiated to ensure that admissions were appropriate and lengths of stays were only as long as clinically indicated. This contract began 1 January 1990. Although all of calendar year 1990's utilization data is not available (due to "a temporary claims processing backlog" at OCHAMPUS), the initial data do not bode well for HMS. Table 19 lists trends in this arena. Lengths of stay have increased - which conflicts with the purpose of utilization management. Average cost per

admission has increased as well. Although it is difficult to determine what the final number of admissions will be, B-JACH issued only 3% more NAS's in FY1990 (152) than in FY1989 (148). Using this data, inpatient psychiatric care costs should show an minimum increase of approximately $ 500,000 (14%) when all of FY1990's claims are finally processed.

Table 19. HMS Utilization Trends

Data Collection Dates	Number of Admissions	Average Length of Stay Group I/Group II	Average Cost Per Admission
Oct 88 - Sep 89	216	28.0/29.3	$ 14,000
Apr 89 - Mar 90	234	27.8/31.8	$ 14,750
Oct 89 - Sep 90	163*	29.6/35.9	$ 16,445

* Incomplete data due to claims processing backlog.

PARTNERSHIP WITH CIVILIAN PSYCHIATRIC FACILITY

Current regulations regarding the use of internal and/or external partnership with civilian health care organizations are included in Appendix C. Essentially, the regulation allows for civilian personnel to come into our facility and practice, thereby extending our facility's professional capacity, or our military health care professionals can go

into their facilities to provide care for CHAMPUS beneficiaries, thereby saving the costs of professional services billings to CHAMPUS. Medical equipment can also be shared under this agreement.

Using data from B-JACH NASs issued for inpatient psychiatric care during FY 1989 and FY 1990, percentages were calculated for which facility was capturing the most business in the B-JACH catchment area beneficiary market. One of the benefits of issuing NASs retroactively (at least to my benefit) is the civilian facility is then listed on the paperwork. This does not occur in the normal process. This was an important tool for my data collection, as OCHAMPUS refused to provide any facility specific information. Of the 301 NASs issued, 264 were issued retroactively. Market share for each facility was based on calculations from these 264 records. Ninety-three percent of all B-JACH CHAMPUS patients use one of three local facilities: Briarwood, Charter, or River North (see Appendix D for map of each facility's location). Each of these facilities provide complete mental health care to include: child and adolescent care, substance abuse, and other common mental health diagnoses. Table 20 depicts their utilization by B-JACH patients from FY 89 and FY 90.

Table 20. Civilian Psychiatric Facility Market Share

Facility	Number of CHAMPUS Admits	Percent Total
Briarwood	139	53%
Charter L.C.	49	19%
River North	56	21%

* Facility changed ownership/name during time period.

Referrals from four physicians on the psychiatric staff, as well as referrals from the Fort Polk Alcohol and Drug Program, accounted for 92% of all NAS generation for inpatient psychiatric care during this two year time period. Table 21 reflects the number of NASs that each physician/program referred, as well as the number that were issued retroactively. The personnel of the Fort Polk Alcohol and Drug program were very effective in following correct procedures for obtaining a NAS for Inpatient Psychiatric care. The B-JACH psychiatric staff did not fare as well, with an average of 93% of all NASs issued retroactively.

Table 21. NAS's by Provider for Civilian Care

Provider	Number of NAS's Referred	Number of NAS's Retroactive
Alcohol & Drug	24	3 (12.5%)
B-JACH Staff(A)	20	20 (100%)
B-JACH Staff(B)	10	10 (100%)
B-JACH Staff(C)	127	115 (91%)
B-JACH Staff(D)	96	91 (95%)

Analyzing the market share of each facility by each provider (excluding Drug and Alcohol because of limited information) is listed in Table 22. There is some degree of difference between utilization among the physicians for the different facilities, although it is not statistically significant.

Table 22. Market Share of Facility by Provider

Physician	NASs for Three Facilities by Provider		
	Briarwood	Charter	River North
Physician A	13 (65%)	4 (20%)	3 (15%)
Physician B	5 (50%)	4 (40%)	0 (0%)
Physician C	55 (48%)	24 (21%)	25 (22%)
Physician D	55 (61%)	8 (9%)	23 (25%)
Totals	128 (92)	40 (82%)	51 (91%)

The reason it is important to analyze this aspect of utilization is due to the fact that once statements are issued retroactively and circumvent the standard processing system, it is possible for the

physician to use his influence with the patient to direct the patient to a specific facility for care. Quoting the CHAMPUS regulation (DOD 6010.8-r, p.9-5):

> "Conflict of interest includes any situation where an active duty member of the Uniformed Services or civilian employee of the United States Government, through an official federal position has the apparent or actual opportunity to exert, directly or indirectly, any influence on the referral of CHAMPUS beneficiaries to himself/herself or others with some potential for personal gain or the appearance of impropriety."

Although there is no substantive evidence available to demonstrate that any staff physicians are currently benefiting from CHAMPUS referrals, there had been situations in the past when staff physicians were "moonlighting" at local facilities which gave the appearance of favoritism to that psychiatric facility. Briarwood receives the largest majority of B-JACH's psychiatric care patients (60 percent in FY 90), even though they are neither less costly nor provide more comprehensive services than their competitors.

In my interview with the Administrator from Charter Hospital of Lake Charles, he felt at a marked disadvantage because he believed he was "not competing on a level playing field" in regard to Briarwood's

favored status with our psychiatric professional staff. This impression of favoritism could have a negative impact on B-JACH.

All three institutions are interested in participating in a partnership program, or any other agreement which would give them exclusive rights to B-JACH's psychiatric patients. Two of the three facilities had submitted proposals in previous years in hopes of going into a partnership (the other facility claimed to not know of this opportunity at that time).

B-JACH chose not to move forward with a partnership at that time due to several factors. There had been an internal partnership agreement made during 1989 with a group of mental health care providers. Unfortunately, they consistently failed to provide the psychiatric providers at designated clinic times as they had agreed upon, creating tremendous problems with last minute appointment cancellations and endless administrative interventions which were very time consuming. The partnership was terminated by B-JACH because of tremendous dissatisfaction with the partnership group. Secondly, the partnership regulation is rather narrow in the scope of its use (their providers here/our provider there).

All three facilities are certainly interested in becoming exclusive providers of psychiatric health care for B-JACH CHAMPUS patients. At current reimbursement rates (average $500/day), it would be extremely lucrative for them to do so as it represents more than $ 3.5 million in revenues in a local market that is extremely economically depressed. Data have shown that the B-JACH catchment area's average daily government cost for an admitted psychiatric patient is 17 percent $ 73/day above the Group 2 MEDDAC average. Given the current local environment, it is not unrealistic to obtain a reimbursement rate of $350 per day or less for an exclusive referral policy of our patients to their facility. During an interview with one administrator, he used this figure as a reasonable starting point for entering into an agreement with B-JACH.

Another important aspect of establishing the suitability of entering into a partnership agreement is analyzing the reason for issuing past NASs. HSC's policy states one of three reasons must be presented at the time an NAS is issued by the MTF: A: Facilities not available; B: Professional capability not available; or C: Medically inappropriate. All NASs issued for inpatient psychiatric care during FY 1989 and 1990 were issued with the explanation of, "A: Facilities not available."

A partnership agreement will not assist us in extending our bed capacity for psychiatric care (maximum 18 bed capacity). The current occupancy rate averages between 40-50%. The Chief of Inpatient Psychiatry also stated that one psychiatrist is fully capable of managing the treatment of the full capacity of the ward, 16 patients.

VETERANS' ADMINISTRATION/DOD RESOURCE SHARING AGREEMENT

Interviews were conducted with key staff members of the Alexandria Veterans' Administration Medical Center (AVAMC) during the year, and the possibility of entering into a VA-DOD Resource Sharing Agreement for inpatient psychiatric care was discussed.

AVAMC currently has a 60 operating capacity for inpatient psychiatric care. It has another 20 bed ward that is currently not utilized due to budget restrictions which preclude the staffing necessary to operate the additional beds. Its current operating capacity of 60 beds averages an occupancy rate in excess of 90 percent. The vast majority (95%) of all inpatient psychiatric care patients are male. Currently, they do not conduct any inpatient substance abuse rehabilitation (only an

outpatient program) nor do they possess the professional capability to treat children or adolescents.

Initial meetings targeted the over 17 age category who were not admitted for substance abuse. The key diagnoses group in this category are depressions (approximately 44 percent of all diagnoses).

Before AVAMC completed the listing of diagnoses they would be able to treat, they provided an initial estimate of cost per day of approximately $350. Also, our patients (CHAMPUS beneficiaries) would have the lowest priority of care as dictated by VA-DOD regulations.

USE OF ALTERNATIVE OUTPATIENT PSYCHIATRIC THERAPY

The Chief of Inpatient Psychiatry was very amenable to this type of new treatment. The various civilian psychiatric facilities are beginning to use alternative outpatient modalities as well, but usually only when the utilization management regarding reimbursements of the patient's insurance policy demands it. In discussing the B-JACH population, the Chief of Inpatient Psychiatry agreed that patients with a diagnosis of depression would be an effective group to target initially.

Usually, the patient is still admitted for an initial analysis and a treatment plan is prepared. This creates a problem if the patient has been awarded an NAS, because with CHAMPUS, B-JACH would then disengage from that patient's care. This patient population would have to be admitted to our facility,

Because we do not possess a child psychologist/ psychiatrist on staff, we would not be able to extend our initial test group to include children and adolescents. However, in my discussions with the Administrator of one of the local civilian psychiatric hospitals, he would gladly work with us to implement more alternative therapies using increased outpatient treatment versus the inpatient model currently used for all CHAMPUS patients.

As noted earlier, alternative outpatient care averages from 25 to 50 percent of the costs of traditional inpatient treatment. Given that CHAMPUS currently pays an average of $501/inpatient day with an average total admission cost of $14,401, the cost savings of implementing alternative outpatient care could be extremely high.

GAO estimates that medical care provided within MTFs costs from 43 to 52 percent less than CHAMPUS funded care (GAO 1990). Even more dramatically, in two tests projects conducted for recapturing

inpatient psychiatric care from CHAMPUS to the MTF, the cost savings averaged 71 percent of the previous CHAMPUS costs. Using our average cost per admission for inpatient mental health care of $ 14,401, our costs would drop to approximately $ 4,320 per admission using the GAO cost savings estimate. If you combine recapture of the CHAMPUS patient (diagnoses of depression) and combine it with alternative outpatient treatment (50 % the cost of inpatient treatment), the average cost per treatment for this diagnosis could fall to approximately $ 2,160 per patient, a cost savings of approximately $ 12,241 for one patient.

We could implement alternative outpatient care in conjunction with a civilian psychiatric hospital as well. Using the average admission rate of $ 14,401, and applying alternative treatment for children and adolescents, a conservative 50 percent cost savings figure would save $ 7,201 per patient.

DISCUSSION

No "one" alternative or change implemented singularly is the best course of action to take to lower the rate of inpatient CHAMPUS

psychiatric care growth for the B-JACH catchment area. A hybrid of the various courses of action will produce the largest cost savings. In reviewing the important points of the findings, a clear path for the best solution develops.

The only group of patients in which B-JACH can directly effect changes in utilization is that group of patients who receive Non-availability statements through the B-JACH CHAMPUS advisor. During FY 89, B-JACH issued 149 NASs. During FY 89, OCHAMPUS was billed for 241 admissions. 94% of all admission require an NAS, 227 in FY 89. So, of the total population that required a NAS (227), B-JACH issued 149 or 66% of the 227.

The total cost for the government for inpatient psychiatric care FY 89 was $ 3,470,731. The total cost of the amount that can be associated with B-JACH NAS utilization is 66%, or $ 2,290,682.

From analyzing past utilization patterns for the patient population, several key points are made. The psychiatric utilization rates of the population represent their demographic proportions (68% female, 32% male). The rate of growth does appear to be slowing from the number of NASs issued from B-JACH in FY1989 as compared to FY1990. From initial data, this was not as a result of the

implementation of the HMS review contract. When compared to other Group 2 MEDDACs, B-JACH reflects similar utilization rates. There is nothing unique about the rate of psychiatric utilization in Louisiana. It is consistent with others in this same grouping.

Three main groups make up 80% of total utilization for inpatient psychiatric care: 35% are under the age of 18 years old; 34% are eighteen or older with a diagnosis of depression; and 11% are eighteen or older with a diagnosis of substance abuse. These groups have been segmented differently than in the initial utilization analysis due to the fact that B-JACH does not have the professional capability on staff, nor the plant facility to treat children and adolescents (<18 years old). This population's exclusion from the remaining population changed the percentage of utilization in the remaining groups, as the <18 year old group has high instance of substance abuse and various forms of depression.

Excess capacity to treat more patients in the psychiatric ward does exist, with the most recent year (FY 90) reflecting a utilization rate of 43 percent. Adding 45 admissions (depressions > 17) adds 630 occupied bed days (average LOS 14 days). This would change the occupancy rate to 54 percent. FY 89's occupancy rate was also 54

percent. The Chief of Inpatient Psychiatry did not feel that this increase would require an increase in staffing ward personnel.

However, it is difficult to calculate specific direct patient costs for the ward because neither UCAPERS nor Monitrend® data used specific, identifiable costs as the basis for making their cost comparisons. Comparing our costs to other MEDDAC costs is not particularly valid because the costs are not associated with specific psychiatric care, but the costs of each hospital in total and then averaged. The GAO study on recapturing inpatient psychiatric care from CHAMPUS did use specific costs which resulted in the 70 percent cost savings estimate.

The increase in the use of retroactively issued NASs also appears to be a trend throughout Health Services Command and is not a specific problem of B-JACH. It is difficult to estimate if any decrease in issuance of the NAS would occur if B-JACH, and other HSC MEDDACs, properly enforced the standard CHAMPUS guidelines regarding NASs. One can assume it would, or why would they have put the policy in place? Unfortunately, there is no incentive on the part of B-JACH to carefully manage this issue because our budget does not suffer when NASs are over-utilized. If DOD wants to reduce CHAMPUS costs, it must implement policies that make the local area commander more

accountable for CHAMPUS dollars. Of course, Gateway answers this challenge.

The utilization patterns of civilian facilities in the local area does reflect an imbalance in market share which is not due to better facilities or lower prices, but could be construed as favoritism. This problem could be alleviated by entering into an agreement with one facility for providing psychiatric care with all facilities given the right to participate in submitting bid proposals. The use of a partnership program agreement does not appear to be the best alternative for extending psychiatric care capabilities for B-JACH given the many new programs that have become available and are more flexible.

B-JACH should take advantage of being a large supplier of "customers" to the local psychiatric facilities. England Air Force Base, located in Alexandria, is targeted for closure during the coming years. Both Briarwood and River North are located in Alexandria, and the majority of the approximately 60 persons per year that receive NASs from England Air Force Base for psychiatric care, use one of these two facilities. Boeing Industries recently announced the closure of its plant in Lake Charles. The administrator for Charter of Lake Charles informed me that Boeing was one of the few local companies that had

excellent mental health care benefits for its employees. These three psychiatric hospitals are eager to get exclusive rights to our patient population.

Implementing an agreement using one of the facilities as a preferred provider organization under the Gateway concept would work the most effectively. Initially, a 70% reimbursement rate will be assumed (as compared to current rates, $350/day versus $500), but it is certainly possible that it might be even lower than that figure. B-JACH would retain administrative control over the cases, thus not disengaging from care when the patient moves to the civilian facility. B-JACH would also remain the utilization manager for care in the civilian facility. This would assist our professional staff in coordinating with the their staff regarding treatment programs and encouraging and ensuring the use of alternative outpatient programs when appropriate.

After analyzing the pros and cons of entering into a VA-DOD Resource Sharing Agreement, it is not as flexible nor convenient for B-JACH, nor our patients who would be subject to the agreement, as compared to a civilian facility. The price is not particularly competitive ($350), and the segment of the patients they could treat is too narrow (at least 46% of our patients would have to receive care elsewhere). We

would have to seek additional agreements to manage our psychiatric care program. There could also be problems regarding our female patients feeling out of place in what is almost an all male treatment facility. Also, if AVAMC experienced any surges in patient utilization or decreases in budget dollars, CHAMPUS patients have the lowest priority for care.

The best option for controlling our CHAMPUS costs, and actually decreasing them, is a combination of: 1. increasing the utilization in our own facility, targeting the depressed adult population for recapture as well as using alternative outpatient treatment; 2. entering into an agreement with a local facility for providing all care outside of B-JACH at a 70% reimbursement rate; 3) retain utilization management control of patients; and 4) target all appropriate groups for alternative outpatient care when indicated.

Estimate of Cost Savings:

152 patients will be used for the basis of our analysis for cost savings. This represents the number of NASs B-JACH issued in FY1990.

1. Recapture Adults diagnosed for Depression: On the average, 45 patients are adults diagnosed with a form of depression each year. The

average cost per admission was $ 14,401 in FY 89. Total costs this group represents under current rates (14,401 x 45) = $ 648,045.

The estimated cost savings of recapturing inpatient psychiatric care per GAO studies are 70%. By recapturing this patient population and treating them in B-JACH, (.3 x 648,045) costs would = $ 194,414. A cost savings of $ 453,631. If you additionally managed this group of patients at B-JACH using alternative outpatient care. However, because the inpatient cost of psychiatric treatment is already so much less in the DOD system than the civilian sector, using alternative outpatient treatment modalities would unlikely generate the 50 percent cost savings that it has in the civilian sector. There are currently no data available to estimate the cost savings the alternative care model would generate within the DOD sector because of the limited use of this model of psychiatric treatment in the DOD health care system. B-JACH should use alternative outpatient treatment for this patient group, but no additional cost savings will be estimated for this model due to lack of data. Recapturing this population (45 diagnoses of depression) would generate a cost savings of $ 453,631 for the CHAMPUS budget.

2. Alternative Outpatient Care for Children/Adolescents: The number of patients less than 18 years old averages 53 per year. The average cost

per admission = $14,401 and total costs for this group equals 53 x $14,401 = $ 763,253. A 70% reimbursement rate would bring the average admission cost down to $10,081 with total costs for 53 patients = $534,293. A cost savings of $ 228,960. Implementing an alternative outpatient treatment program at the 50% rate, costs per admission would = $ 5,041; total costs $ 267,172. This represents a cost savings of 53 x $ 5,041 or $ 267,173. Two of the three psychiatric facilities have outpatient clinics located close to Fort Polk. The total cost savings of using alternative outpatient treatment on children and adolescents under a 70% reimbursement rate is estimated to be $ 496,133.

3. 70 % Reimbursement Rate: The remaining 47 admissions would receive the 70% rate, current costs = $ 14,401 x 47 = $676,847. With the cost at a 70% reimbursement rate, average admission cost would equal $ 10,081 and total costs for 47 admissions would then equal $ 473,793; a savings of $ 203,054.

4. Total Cost Savings Estimate: Implementing these three changes in the program results in a cost savings of $ 1,152,818. This brings the cost the government pays for inpatient psychiatric care for this catchment

area from $ 3,470,731 down to $ 2,317,913, a decrease in costs of 33 percent. If you only calculate the savings compared to the population B-JACH issues NASs for (66% of total), it represents a change in costs from approximately $ 2,290,682 down to $ 1,137,864 - a decrease in costs of 50 percent! Additional savings could be realized by closely monitoring utilization management and applying alternative outpatient therapy to more diagnoses. Tables 23 and 24 outline the costs and savings of this program.

Table 23. Projected Cost per Admission

Category	New Cost	Total Cost
Depressed Adults	$ 2,161	$ 97,207
< 18 Years Old	$ 5,041	$ 267,173
All Others	$ 10,081	$ 473,793
Total		$ 838,173

Table 24. Projected Cost Savings with Totals

Category	Savings Per Patient	Total
Depressed Adults	$ 12,241	$ 550,838
< 18 Years Old	$ 9,361	$ 496,133
All Others	$ 4,320	$ 203,054
Total		$ 1,250,054

CONCLUSIONS

These cost savings are not overstated. The average cost of admissions for depressions and children/adolescents are higher than the average rate used in these calculations of $ 14,401. When utilized, alternative outpatient treatment does result in tremendous cost savings. Recapturing psychiatric care back to the MTF from CHAMPUS has resulted in cost savings of 70%. HSC is highly encouraging MTFs to seek out projects for Gateway. Recapturing control over our inpatient psychiatric patients is an ideal project for B-JACH to begin its entry into the Gateway program.

Costs to Implement Program:

Headquarters HSC (message dated 27 June 1991) has already authorized 16 positions (2 Medical Corps, 2 Nursing Corps, 4 Enlisted, and 8 Civilian) to assist in initiating Gateway to Care projects at B-JACH. Currently, B-JACH has two psychiatrists on staff, though only one is required by TDA. B-JACH would need to retain both psychiatrists on staff to manage this program. In addition, a nurse to coordinate the utilization management of the program would be required. These positions are now shown as authorized, but not required, on the TDA. If a military nurse cannot be sent to fill the position, a GS-9 utilization management reviewer ($34,000) would need to be hired to fill the position. The Chief of Inpatient Psychiatric Care did not believe any additional personnel needed to be hired to support the additional 45 patients that the inpatient ward of B-JACH would recapture.

Benefits to our patient population:

All costs analyzed in this study were based on the actual costs billed to the government. However, patients are required to pay a portion of the costs under CHAMPUS. In fiscal year 1989, average

inpatient mental health care costs charged to each patient were $ 940. Under Gateway, the commander can waive any co-payment by the beneficiary utilizing the program.

Outside of the financial incentive, many beneficiaries who utilize inpatient mental health care services do so because they cannot afford the 20-25% co-payment required for outpatient care. Treating depressed women on an outpatient basis (the majority of whom are spouses of active duty personnel with children) at B-JACH creates less stress on the family unit, as well as ensuring effective outpatient treatment is provided. Currently, there is little patient follow-up after discharge from one of the civilian facilities . Treating children using alternative outpatient therapy puts them back into the family environment more quickly while still receiving intensive outpatient management. Opening up new opportunities for mental health care with benefit our beneficiary population in providing them more options for models of psychiatric care, yet less expensively.

Caution of Increasing Demand

The demand for inpatient psychiatric care appears to be slowing down. We do not want to sell this program to a larger group than we

are currently serving: the 152 beneficiaries who received an NAS in FY 90. In receiving accountability for our inpatient psychiatric care budget, we must ensure that we meet their demand and do not "create" more demand by selling this program to people who otherwise would not have utilized it. This is actually a very small group of beneficiaries that are accounting for a large portion of the CHAMPUS budget. It should still be managed carefully, using the Health Benefits Advisor as the control point into the program.

Recommendations

After analyzing many issues impacting on the growth of inpatient psychiatric care, I believe the following recommendations should be implemented to lower the growth and total costs for CHAMPUS inpatient psychiatric care costs:

1. Request permission from HSC to initiate a Gateway project for recapturing 66% of the current CHAMPUS inpatient psychiatric care budget, approximately $ 2,290,682.

2. Implement an agreement for exclusive care of our patient population at a 70% reimbursement rate at a minimum, 60% if possible, with a local civilian psychiatric facility.

3. Recapture the adult depression population in our own facility and also use alternative outpatient therapy.

4. Retain utilization management functions for external patients, enforce strict UM guidelines and utilize alternate outpatient treatment when possible and appropriate.

5. Enforce strict internal control over participation in this program and ensure no NASs are issued, nor issued retroactively. We now have facilities and staff capable of treating almost all (98%) mental health diagnoses.

REFERENCES

American Hospital Association Environmental Assessment 91/92. (1991). American Hospital Association. Chicago, IL

American Hospital Association Hospital Statistics: A comprehensive summary of U.S. Hospitals 1990-1991. American Hospital Association. Chicago, IL

Fox, B.B. & Gottheimer, D.L. (1990). Meeting managed mental health demands. Health Care Strategic Management, 8(7), pp. 15-17.

Goldstein, J.M. & Horgan, C.M. (1989). Inpatient and outpatient psychiatric services: Substitutes or complements? Hospital and Community Psychiatry, 39(6), pp. 632-635.

Hagin, D. (1990). Demand for psychiatric care services continues to grow. Health Care Strategic Management. 7(9), p. 1, pp. 20-22.

Hagin, D. (1989). Market memo: Psychiatric hospitals may be high-risk investments. Health Care Strategic Management, 7(10), p. 1, pp. 18-23.

Hoppszallern, S. (1991). *Meditrends in psychiatric services.* Meditrends 1991-1992, pp. 63-77.

Impact Weekly (May 3, 1991) Hospital expenses rose 11.1% in 1990, p.5.

Larkin, H. (1989). Managed mental health moves inpatient out. Hospitals. 63(8), pp. 64-65.

Sharfstein, S.S. (1990). Utilization management: Managed or mangled psychiatric care? The American Journal of Psychiatry. 147(8), pp. 965-966.

Tischler, G. L. (1990). Utilization management of mental health services by private third parties. The American Journal of Psychiatry. 147(8), pp. 967-973.

United States General Accounting Office (1990). Potential Expansion of the CHAMPUS reform initiative, T-HRD-90-17.

United States General Accounting Office (1990). Potential for savings by treating CHAMPUS in military hospitals, HRD-90-131.

United States General Accounting Office (1989). Defense health care: Workload reductions at military hospitals have increased CHAMPUS costs, HRD-89-47.

United States General Accounting Office (1988). Further opportunities to increase the sharing of medical resources, HRD-88-51.

United States General Accounting Office (1987). CHAMPUS reform initiative: Unresolved issues, T-HRD-87-4.

Westbrook, L. (1988). The changing nature of mental health care. Business and Health. 6(1), pp. 36-38.

Zimet, C.N. (1989). The mental health care revolution: Will psychology survive? The American Psychologist. 44(4), pp. 703-708.

LIST OF TABLES

Page

APPENDIX A:

DEFINITIONS

or psychological circumstances exist based upon a written request documenting that:

(a) the patient is suffering from an acute mental disorder or an acute exacerbation of a chronic mental disorder that results in the patient being put at significant risk to self or of becoming a danger to others, and the patient requires a type, level, and intensity of otherwise authorized service that can only be provided in an acute care inpatient setting; or

(b) the patient has a serious medical condition apart from his or her psychiatric condition that requires a type, level, and intensity of service that can only be provided in an acute care inpatient setting and the person continues to need psychiatric care, but cannot obtain it on an outpatient basis because of his or her inpatient status. The medical condition and services provided must be otherwise covered under CHAMPUS.

6. Emergency inpatient hospital services. *In the case of a medical* emergency, benefits can be extended for medically necessary inpatient services and supplies provided to a beneficiary by a hospital, including hospitals that do not meet CHAMPUS standards or comply with the provisions of title VI of the Civil Rights Act (reference (z)), or satisfy other conditions herein set forth. In a medical emergency, medically necessary inpatient services and supplies are those that are necessary to prevent the death or serious impairment of the health of the patient, and that, because of the threat to the life or health of the patient, necessitate, the use of the most accessible hospital available and equipped to furnish such services. The availability of benefits depends upon the following three separate findings and continues only as long as the emergency exists, as determined by medical review. If the case qualified as an emergency at the time of admission to an unauthorized institutional provider and the emergency subsequently is determined no longer to exist, benefits will be extended up through the date of notice to the beneficiary and provider that CHAMPUS benefits no longer are payable in that hospital.

a. Existence of medical emergency. A determination that a medical emergency existed with regard to the patient's condition;

b. Immediate admission required. A determination that the condition causing the medical emergency required immediate admission to a hospital to provide the emergency care; and

c. Closet hospital utilized. A determination that diagnosis or treatment was received at the most accessible (closest) hospital available and equipped to furnish the medically necessary care.

C. PROFESSIONAL SERVICES BENEFIT

1. General. Benefits may be extended for those covered services described in this section C., that are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers, as set forth in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, exceptions, limitations, or exclusions as may be otherwise set forth

APPENDIX B:

GUIDELINES FOR ISSUING NAS

family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this subsection A.6., is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to section F. of Chapter 4 of this Regulation).

7. Nonavailability Statement (DD Form 1251). In some geographic locations or under certain circumstances, it is necessary for a CHAMPUS beneficiary to determine whether the required medical care can be provided through a Uniformed Services facility. If the required medical care cannot be provided by the Uniformed Services facility, a Nonavailability Statement will be issued. When required (except for emergencies), this Nonavailability Statement must be issued before medical care is obtained from civilian sources. Failure to secure such a statement will waive the beneficiary's rights to benefits under CHAMPUS, subject to appeal to the appropriate hospital commander (or higher medical authority).

a. Rules applicable to issuance of Nonavailability Statement. The ASD(HA) has issued DoD Instruction 6015.19 (reference (gg)) that contains rules for the issuance of Nonavailability Statements. Such rules may change depending on the current situations.

b. Beneficiary responsibility. The beneficiary shall ascertain whether or not he or she resides in a geographic area that requires obtaining a Nonavailability Statement. Information concerning current rules may be obtained from the CHAMPUS fiscal intermediary concerned, a CHAMPUS HBA or the Director, OCHAMPUS, or a designee.

c. Rules in effect at time civilian care is provided apply. The applicable rules regarding Nonavailability Statements in effect at the time the civilian care is rendered apply in determining whether a Nonavailability Statement is required.

d. Nonavailability Statement must be filed with applicable claim. When a claim is submitted for CHAMPUS benefits that includes services for which a Nonavailability Statement is required, such statement must be submitted along with the claim form.

B. INFORMATION REQUIRED TO ADJUDICATE A CHAMPUS CLAIM

Claims received that are not completed fully and that do not provide the following minimum information may be returned. If enough space is not available on the appropriate claim form, the required information must be attached separately and include the patient's name and address, be dated, and signed.

1. Patient's identification information. The following patient identification information must be completed on every CHAMPUS claim form submitted for benefits before a claim will be adjudicated and processed:

a. Patient's full name.

b. Patient's residence address.

c. Patient's date of birth.

APPENDIX C:

PARTNERSHIP GUIDELINES

P. MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM.

The Secretary of Defense, or designee, may enter into an agreement (external or internal) providing for the sharing of resources between facilities of the uniformed services and facilities of a civilian health care provider or providers if the Secretary determines that such an agreement would result in the delivery of health care in a more effective, efficient or economical manner. This partnership allows CHAMPUS beneficiaries to receive inpatient and outpatient services through CHAMPUS from civilian personnel providing health care services in military treatment facilities and from uniformed service professional providers in civilian facilities. The policies and procedures by which partnership agreements may be executed are set forth in Department of Defense Instruction (DoDI) 6010.12, "Military-Civilian Health Services Partnership program." The Director, OCHAMPUS, or a designee, shall issue policies, instructions, procedures, guidelines, standards, or criteria as may be necessary to:

--provide support for implementation of DoDI 6010.12;
--to promulgate and manage benefit and financial policy issues; and
--to develop a program evaluation process to ensure the Partnership Program accomplishes the purpose for which it was developed.

1. Partnership agreements. Military treatment facility commanders, based upon the authority provided by their respective Surgeons General of the military departments, are responsible for entering into individual partnership agreements only when they have determined specifically that use of the Partnership Program is more economical overall to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS Program. All such agreements are subject to the review and approval of the Director, OCHAMPUS, or designee, and the appropriate Surgeon General.

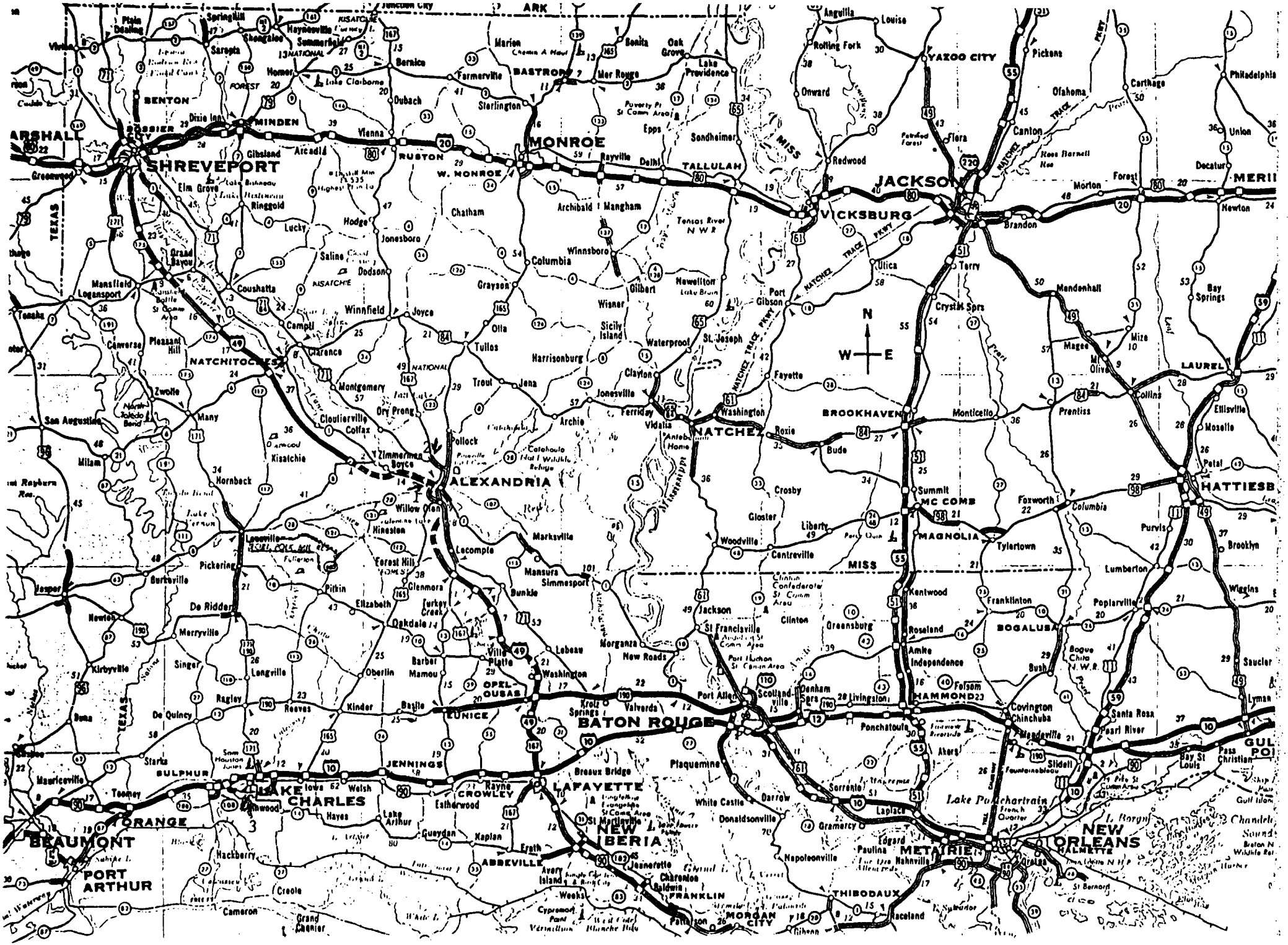
a. External partnership agreements. The external partnership agreement is an agreement between a military treatment facility commander and a CHAMPUS-authorized institutional provider, enabling Uniformed Services health care personnel to provide otherwise covered medical care to CHAMPUS beneficiaries in a civilian facility. Authorized costs associated with the use of the facility will be financed through CHAMPUS under normal cost-sharing and reimbursement procedures currently applicable under the basic CHAMPUS. Savings will be realized under this type agreement by using available military health care personnel to avoid the civilian professional provider charges which would otherwise be billed to CHAMPUS.

b. Internal partnership agreements. The internal partnership agreement is an agreement between a military treatment facility commander and a CHAMPUS-authorized civilian health care provider which enables the use of civilian health care personnel or other resources to provide medical care to CHAMPUS beneficiaries on the premises of a military treatment facility. These internal agreements may be established when a military treatment facility is unable to provide sufficient health care services for CHAMPUS beneficiaries due to shortages of personnel and other required resources. In addition to allowing the military treatment facility to achieve maximum use of available facility space, the internal agreement will result in savings to the Government by using civilian medical specialists to provide inpatient care in Government-owned facilities, thereby avoiding the civilian facility charges which would have otherwise been billed to CHAMPUS.

#Amendment 2 (Ch 24, 11/5/90)

APPENDIX D:

MAP OF PSYCHIATRIC FACILITIES



1: Briarwood 2: River North 3: Charter